

Registration District **MO OCT 18 1944** / 01

Primary Registration District No. 4427

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Bolivar
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME John Champe Richter
3. (b) If veteran name war _____ 3. (c) Social Security No. _____

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Merle 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased December 16 1911
(Month) (Day) (Year)

8. AGE: Years 29 Months 9 Days 5 If less than one day hr. _____ min. _____

9. Birthplace Bolivar Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Filling Station operator

11. Industry or business _____

MOTHER FATHER
12. Name Robert Richter
13. Birthplace Polk
(City, town, or county) (State or foreign country)
14. Maiden name Pauline
15. Birthplace Polk Mo
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Dr. B. K. Richter

(b) Address Bolivar Missouri

17. (a) Burial (b) Date thereof Sept 23 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Hutcherson & Co.
(b) Address Bolivar

19. (a) 9/23/44 (b) J. F. Hutcherson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Polk
(c) City or town Bolivar
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 21
year 1944 hour 1 minute a. M.

21. I hereby certify that I attended the deceased from Northland, 19____, to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Shot him self with a shot gun
Due to unknown cause
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy /

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 630

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. B. Hutcherson coroner (M.D. or other)
Address Bolivar Mo Date signed Sept 22

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

167

RECEIVED

District Health Officer No. 7,

District File Number 10-40-146/

Date Filed 10-9-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Beet Regan

Licensed Embalmer No. 3979

P. O. Address Bolivar, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32889**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **901**

Primary Registration District No. **4422**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Polk**
(b) City or town **Bolivar**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME **John Champe Richter**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **29** Months **9** Days **5** If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant **Registrar**

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) -If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: **Sept 21** day **1940** year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him _____ alive on _____ 19 _____ and that death occurred on the date and hour stated above.
Immediate cause of death **Shot himself with a shotgun** Duration _____

22. Cause unknown _____

Due to **at his home 11-PM.**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **suicide**

(b) Date of occurrence **Sept 21-1940**

(c) Where did injury occur? **city Polk mo** (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **at his home**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **Phelton Coroner** (M. D. or other)

Address **Bolivar mo** Date signed **Sept 22**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY INFORMATION

